Medical examiners: Independent or ignorant?

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The medicolegal conditions in Colorado before the changes introduced in 1997, as described in the article by Rossie and Gretzinger in this issue of Pain Research & Management (pages 9-10), still exist in Canada and elsewhere. So-called independent medical examiners (IMEs) paid by the insurance companies repeatedly testify that injured motorists complaining of persistent pain and dysfunction have no real organic basis for their complaints and that they are fit to return to work. These experts are from various specialties but are frequently orthopedic surgeons, neurosurgeons, neurologists, physiatrists and psychiatrists. Psychologists and some manual therapists are also involved. Most appear genuine in their beliefs that there is nothing wrong with these patients. This is not surprising because actual knowledge about the pathophysiology of chronic pain is not a requirement to qualify as an expert in these matters.

The field of pain and its management, and knowledge of the pathophysiological processes causing it have reached a high degree of scientific sophistication built on a great deal of solid data. The two major texts on chronic pain (1,2) individually outweigh pound for pound Harrison’s Textbook on Internal Medicine, yet most IMEs encountered here appear to be unaware of the existence of these texts. Chronic pain is the one field where genuine ignorance is not a problem for the practitioner. Any demonstrated knowledge tends to be outdated, eg, Waddell et al’s (3) nonorganic signs and Ramsford et al’s (4) pain drawings – all supposedly findings of nonorganic, ie, noncompensable pain – are frequently cited. It has long been observed and is increasingly understood, however, that such findings are to be expected in various neuropathic pain states (5,6).

Because these examiners disbelieve the patients who they are asked to see, the encounters are frequently distressing to patients, who often feel degraded and abused. Discourteous and needlessly painful physical examinations are frequently experienced, and a high number of complaints to Colleges ensue, although many patients are often too crushed and too weary of medicolegal matters to lodge their legitimate complaints.

The reasons for the current status should be sought and understood. First, an observed increase in the incidence of ‘whiplash’ type pain and disability is said to have occurred over the past two to three decades – similar in size to increases in other conditions such as asthma and low back pain. There is some indication that the introduction of seat belts, while reducing head injuries, may have contributed to the increase in whiplash injuries; in addition, the growth in traffic may also have contributed to the increase in whiplash injuries (7). Second, abuse of the system by ‘arranged’ collisions appears to have occurred; seats in cars to be rear-ended were apparently for sale on the streets of Toronto at one time. The extent of this practice is not known. Third, attempts by legislators to limit costs while protecting motorists resulted in ‘no fault’ type systems. In 1994 in Ontario, insurance companies were mandated to provide and fund rehabilitation for three years (Bill 164), and in 1996 (Bill 59) for two years. The medical profession was unprepared to take on this task. Overnight, a new industry (modelled on the American systems) sprang up – the case management industry. Individuals operating and running these companies had, as a rule, no knowledge of pain medicine or rehabilitation, nor much other relevant data. They were frequently allied health care professionals – psychologists, former nurses or social workers. A great deal of nonindicated ‘rehabilitation’ ensued. Examples encountered include exercise training, which was provided via long distance telephone calls, and literacy training pro...
vided to a male with post-traumatic headache so severe he refused to open his eyes. Thousands of dollars were billed for such services.

Because 80% of all injured motorists can be expected to recover substantially without therapy (by subtraction of numbers from references 8,9), a considerable number of them were subjected to ‘rehabilitation’ needlessly. A few cases were seen where physical therapies that repeatedly and consistently produced marked increases in levels of pain were administered in the mistaken belief that they would hasten recovery, when, in fact, it is a recipe for producing chronic pain (as used in laboratory experiments to create animal models of chronic pain).

It is, therefore, not correct to blame the insurance industry alone (or lawyers) for the current mess. The medical profession must shoulder much of the blame for the failure to incorporate scientific data regarding persistent pain and dysfunction into the diagnosis and proper management of individuals at risk for chronic pain from soft tissue injuries. It appears likely that about 20% (8,9) of the population is at increased risk for long term pain after trauma. If clinical research to identify these individuals were to be undertaken, allowing optimal therapy to be rendered, it is possible that material reduction of chronic problems could be achieved. The need for subjecting these individuals to the devastating process of IMEs and designated assessment centres (centres where IMEs and functional and vocational capacity assessments are carried out) would be greatly reduced, as would litigation. Both injured motorists and the insurance industry would be winners. Ignorant medical therapists and examiners would be the losers.

While these changes are likely to take some time to be achieved, the changes introduced in Colorado should be a step toward reducing cost, stress and abuse.

REFERENCES
